BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the amendment of ARM 37.85.212 pertaining to resource based relative value scale (RBRVS)	)))	NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENT

TO: All Interested Persons

1. On April 26, 2006, at 3:30 p.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed amendment of the above-stated rule.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who need an alternative accessible format of this notice or provide reasonable accommodations at the public hearing site. If you need to request an accommodation, contact the department no later than 5:00 p.m. on April 17, 2006, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970; e-mail dphhslegal@mt.gov.

2. The rule as proposed to be amended provides as follows. Matter to be added is underlined. Matter to be deleted is interlined.

37.85.212 RESOURCE BASED RELATIVE VALUE SCALE (RBRVS) REIMBURSEMENT FOR SPECIFIED PROVIDER TYPES (1) For purposes of this rule, the following definitions apply:

(a) "Anesthesia units" means time and base units used to compute reimbursement under RBRVS for anesthesia services. Base units are those units as defined by the ~~m~~Medicare program. Time units are 15 minute intervals during which anesthesia is provided.

(b) "Conversion factor" means a dollar amount by which the relative value units, or the base and time units for anesthesia services, are multiplied in order to convert the relative value units to a fee for a service.

(c) "Policy adjustor" means a factor by which the product of the relative value units and the conversion factor is multiplied to increase or decrease the fees paid by ~~m~~Medicaid for certain categories of services.

(d) "Provider's invoice cost" means the actual dollar amount paid by a ~~m~~Medicaid provider for a specific item of durable medical equipment (DME) or supply. It does not include any markup added by the provider.

(e) "Relative value unit (RVU)" means a numerical value assigned in the resource based relative value scale to each procedure code used to bill for services provided by a health care provider. The relative value unit assigned to a particular code expresses the relative effort and expense expended by a provider in providing

one service as compared with another service.

(f) "Resource based relative value scale (RBRVS)" means the most current version of the Mmedicare resource based relative value scale contained in the ~~physicians'~~ Mmedicare Physician Ffee Ssschedule adopted by the Ccenters for Mmedicare and Mmedicaid Ssservices (CMS) of the U.S. Ddepartment of Hhealth and Hhuman Ssservices and published at ~~69~~ 70 Federal Register ~~66235~~ 70116 (November ~~15, 2004~~ 21, 2005), effective January 1, ~~2005~~ 2006 which is adopted and incorporated by reference. A copy of the Mmedicare Physician Ffee Ssschedule may be obtained from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. The RBRVS reflects RVUs for estimates of the actual effort and expense involved in providing different health care services.

(g) "Subsequent surgical procedure" means any additional surgical procedure or service, except for add-ons and modifier 51 exempt codes, performed after a primary operation in the same operative session.

(h) "Usual and customary" means those charges that the ~~m~~Medicaid provider would charge for a particular service in a majority of cases including ~~m~~Medicaid and non-~~m~~Medicaid patients.

(2) Services provided by the following health care professionals will be reimbursed in accordance with the RBRVS methodology set forth in (3):

(a) physicians;
(b) mid-level practitioners;
(c) podiatrists;
(d) physical therapists;
(e) occupational therapists;
(f) speech therapists;
(g) audiologists;
(h) optometrists;
(i) opticians;
(j) providers of clinic services;
(k) providers of EPSDT services;
(l) licensed psychologists;
(m) licensed clinical social workers;
(n) licensed professional counselors;
(o) dentists providing medical services;
(p) providers of oral surgery services;
(q) providers of pathology and laboratory services;
(r) independent diagnostic testing facilities (IDTF); and
(s) school based services.

(3) Except as set forth in (8)~~, (9), (10), and (11)~~ through (12)(a)(vi), the fee for a covered service provided by any of the provider types specified in (2) through (2)(s) is determined by multiplying the RVUs determined in accordance with (7) through (7)(b)(iii) by the conversion factor, which is required to achieve the overall budget appropriation for physician services in House Bill 2 of the 2005 legislative session (the General Appropriations Act of 2005) and then multiplying the product by a factor of one plus or minus the applicable policy adjustor as provided in (4) or (5), if any.

(4) On July 1, 2006, $324,500 total additional funds for state fiscal year 2007 will be applied to well child preventative visits.

~~(4) The reimbursement increases will be effective as follows:~~

~~(a) On July 1, 2005:~~

~~(i) $1,233,000 will be applied to maternity related services;~~

~~(ii) $3,448,000 will be applied to physician related services, that is, those procedures priced by RBRVS and performed by a physician, mid-level practitioner, podiatrist, independent diagnostic testing facility (IDTF), or public health clinic.~~

~~(b) On January 1, 2006, $324,500 additional total funds will be applied to well child preventive visits.~~

~~(c) Policy adjustors will be used to accomplish the funding allocations in (4)(a) and (b).~~

~~(5) A policy adjustor of up to 10% may be applied to family planning services.~~

~~(a) The department's list of specific maternity related services and family planning services as amended through January 1, 2005 is adopted and incorporated by reference. A copy of the list is available on request from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.~~

(5) For state fiscal year 2007, policy adjustors will be used to accomplish the targeted funding allocations, which apply to family planning services, maternity services, and well child preventative visits as directed by the legislature. The department's list of services affected by policy adjustors through January 1, 2006 is adopted and incorporated by reference. The list is available from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(6) The RVUs for most services are adopted from the resource based RBRVS. For most services for which the RBRVS does not specify RVUs, the department sets those RVUs.

(7) The RVUs for a ~~m~~Medicaid covered service provided by any of the provider types specified in (2) are calculated as follows:

(a) if ~~m~~Medicare sets RVUs, the ~~m~~Medicare RVUs are applicable;

(b) if ~~m~~Medicare does not set RVUs but ~~m~~Medicaid sets RVUs, the ~~m~~Medicaid RVUs are set in the following manner:

(i) convert the existing dollar value of a fee to an RVU value;

(ii) evaluate the RVU of similar services and assign an RVU value; or

(iii) convert the average by report dollar value of a fee to an RVU value.

(8) Except for physician administered drugs as provided in ARM 37.86.105(3), clinical laboratory services and anesthesia services, if neither ~~m~~Medicare nor ~~m~~Medicaid sets RVUs, then reimbursement is by report.

(a) Through the by report methodology the department reimburses a percent of the provider's usual and customary charges for a procedure code where no fee has been assigned. The percentage is determined by dividing the previous state fiscal year's total ~~m~~Medicaid reimbursement for RBRVS provider covered services by the previous state fiscal year's total ~~m~~Medicaid billings.

(b) For state fiscal year ~~2006~~ 2007, the by report rate is ~~43%~~ 45% of the provider's usual and customary charges.

(9) For clinical laboratory services for which there is an established fee:

(a) the department pays the lower of the following for procedure codes with fees:

(i) the provider's usual and customary charges for the service; or

(ii) 60% of the medicare fee schedule for physician offices and independent labs and hospitals functioning as independent labs; or

(iii) the established ~~m~~Medicaid fee.

(b) for clinical laboratory services for which there is no established fee, the department pays the lower of the following for procedure codes without fees:

(i) the provider's usual and customary charges for the service;

(ii) the rate established using the by report methodology; or

(A) for purposes of (9)(b) through (9)(b)(iii), the by report methodology means averaging 50 paid claims for the same code that have been submitted within a 12 month span and then multiplying the average by the amount specified in (8)(b).

(iii) the historical comparative value of the procedure as indicated by the reimbursement amount paid by ~~m~~Medicaid and other third party payors for the same procedure within the last 12 months.

(10) For anesthesia services the department pays the lower of the following for procedure codes with fees:

(a) the provider's usual and customary charges for the service;

(b) a fee determined by multiplying the anesthesia conversion factor by the sum of the applicable base and time units, and then multiplying the product by a factor of one plus or minus the applicable policy adjustor, if any;

(c) the department pays the lower of the following for procedure codes without fees:

(i) the provider's usual and customary charges for the services; or

(ii) the by report rate.

(11) For equipment and supplies:

(a) the department pays the lower of the following for durable medical equipment (DME) items with fees:

(i) the provider's invoice cost for the DME; or

(ii) the ~~m~~Medicaid fee schedule as provided in ARM 37.86.1807.

(b) the department pays the lower of the following for DME items without fees:

(i) the provider's invoice cost for the DME; or

(ii) the by report rate provided in (8)(b).

(c) except for the bundled items as provided in (13), the department pays the lower of the following for supply items with fees:

(i) the provider's invoice cost for the supply item; or

(ii) the ~~m~~Medicaid fee schedule as provided in ARM 37.86.1807.

(d) except for bundled items as provided in (13), the department pays the lower of the following for supply items without fees:

(i) the provider's invoice cost for the supply item; or

(ii) the by report rate provided in (8)(b).

(12) Subject to the provisions of (12)(a), when billed with a modifier, payment for procedures established under the provisions of (7) is a percentage of the rate established for the procedures.

(a) The methodology to determine the specific percent for each modifier is as

follows:

(i) The department obtains information from ~~m~~Medicare and other third party payers regarding the comparative value utilized for payment of procedures billed with modifiers.

(ii) The department establishes a specific percentage for each modifier based upon the purpose of the modifier, the comparative value of the modified service, and the medical insurance industry trend of reimbursement for the modifier.

(iii) The department's list of the specific percents for the modifiers used by ~~m~~Medicaid as amended through January 1, 2005 is adopted and incorporated by reference. A copy of the list is available on request from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(iv) Notwithstanding any other provision, procedure code modifiers "80", "81", "82", and "AS", used by assistant surgeons shall be reimbursed at 16% of the department's fee schedule.

(v) Notwithstanding any other provision, procedure code modifier "62" used by cosurgeons shall be reimbursed at 62.5% of the department's fee schedule for each cosurgeon.

(vi) Notwithstanding any other provision, subsequent surgical procedures shall be reimbursed at 50% of the department's fee schedule.

(13) In applying the RBRVS methodology set forth in this rule, ~~m~~Medicaid reimburses in accordance with ~~m~~Medicare's policy on the bundling of services, as set forth in the physicians' ~~m~~Medicare fee schedule adopted by CMS and published in the Federal Register annually, whereby payment for certain services constitutes payment for certain other services which are considered to be included in those services.

(14) Providers must bill for services using the procedure codes and modifiers set forth, and according to the definitions contained in the federal health care administration's common procedure coding system (HCPCS). Information regarding billing codes, modifiers, and HCPCS is available upon request from the health resources division at the address previously stated in this rule.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

3. The Medicaid program provides medical assistance to low income and disabled residents of Montana. The State of Montana and the federal government jointly fund the program. The purpose of this rule amendment is to update the Resource Based Relative Value Scale (RBRVS) fees in accordance with the more recently published relative value units (RVUs) released by Center for Medicare and Medicaid (CMS). The RVUs are backed by costly research done to assure services are reimbursed appropriately and related to actual costs. Work units, malpractice liability, and office/facility practice expenses are included in the RVU calculation.

The RBRVS administrative rule is updated annually to incorporate the updated RVUs and legislative appropriation.

Leaving the rule unchanged is not an option as the RVUs must be updated and a new appropriation for fees must be incorporated into rule. New RVUs should be used to allow Montana Medicaid to utilize the most recent and accurate version of the RBRVs methodology. If the rule was not updated, the RBRVS rule methodology would not take into account updated cost analysis.

The 2005 legislative session has appropriated additional funds in the amount of $324,500 to be applied to well child preventative visits. The increase will be applied to physician-related services that are reimbursed via the RBRVS methodology, that is physicians, mid-level practitioners, podiatrists, independent diagnostic testing facilities (IDTFs), and public health clinics.

This rule change has a $324,500 budget impact and will affect 6,000 health care providers and 84,000 Montana Medicaid clients.

4. Interested persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than 5:00 p.m. on May 4, 2006. Data, views, or arguments may also be submitted by facsimile (406)444-1970 or by electronic mail via the Internet to dphhslegal@mt.gov. The department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

5. The Office of Legal Affairs, Department of Public Health and Human Services has been designated to preside over and conduct the hearing.

/s/ Dawn Sliva
Rule Reviewer

/s/ John Chappuis for
Director, Public Health and Human Services

Certified to the Secretary of State March 27, 2006.